REQUEST FOR USE OF RESTRAINTS, ISOLATION, OR PROTECTIVE EQUIPMENT AS PART OF A BEHAVIOR SUPPORT PLAN

Completion of this form is voluntary. Although completion of this form is voluntary, all the information requested on this form needs to be submitted as part of the approval process. Department approval authority: Wis. Stats. § 50.02(2) and § 51.61(1)(i). Wis. Admin. Code § HFS 83.21(4)(n)4 and § HFS 94.10.

Name – Consumer	Birthdate
Current Address – Consumer	Type of Request ☐ New ☐ Review
City, State, Zip Code	

Name – Guardian	Telephone Number – Guardian

Current Residence – Consumer

- ☐ Personal Residence (same address as above)
- ☐ Licensed or Certified Facility (provide name and address below)
- ☐ Other (describe and provide address below)

Facility Name	Facility Type
Facility Address	Telephone Number
City, State, Zip Code	FAX number

Is the consumer's proposed placement other than the current residence?
☐ Yes (provide name below) ☐ No

Name – Facility	Facility Type
Address – Facility	Telephone Number
City, State, Zip Code	FAX Number

Name – Agency Submitting This Request	Date Submitted
Contact Person	Telephone Number
Agency Address	FAX Number
City, State Zip Code	
Email Address	

DEFINITIONS Check yes or no if the following apply.

Yes	No		
☐	☐	**PHYSICAL RESTRAINTS**	Any device, garment or physical hold that (a) restricts voluntary movement of a person's body or access to any part of the body and (b) cannot be easily removed by the individual.
☐	☐	**ISOLATION**	Physical or social separation from others by actions of staff but does not include separation in order to prevent the spread of communicable disease or cool down periods in an unlocked room as long as presence in the room by the resident is voluntary
☐	☐	**PROTECTIVE EQUIPMENT**	The application of a device to any part of a person's body that *prevents tissue damage or other physical harm* due to a person's behavior and cannot be easily removed by the individual.

If the answer to any of the above definitions is YES, continue.

PERSONAL SUMMARY

Type of Employment

Support Systems

Interests

Dislikes

HEALTH CONSIDERATIONS

Diagnoses

Health Concerns

MEDICATIONS

Medication	Dose	Purpose	Prescribing Physician

HEALTH PROVIDERS

Specialty	Name	Address	Telephone
Primary Physician			
Psychiatrist			
Psychologist / Therapist			
Neurologist			
Other:			
Other:			
Other:			

TARGET BEHAVIOR

Describe or attach the person's challenging behaviors and the situations in which they occur.

Describe or attach the frequency and intensity of the above behaviors.

Describe or attach the patterns that have been observed when the behavior occurs, i.e., what triggers the behavior, etc.

Describe or attach the plan currently being done proactively, to prevent these behaviors from occurring.

PREVIOUS SUPPORT STRATEGIES OR INTERVENTIONS

List and explain or attach previous support strategies or interventions, when they were tried, how long they were tried and the outcomes

1. Support Strategy

Outcome

2. Support Strategy

Outcome

3. Support Strategy

Outcome

4. Support Strategy

Outcome

CURRENT AND PROPOSED STRATEGIES

Describe or attach the current and proposed strategies and safeguards for target behaviors. Include staffing patterns, level of supervision, restrictions or limitations. Attach the current support plan / behavioral support plan, OT and PT evaluations, physicians orders, informed consent by the consumer or guardian

WHAT IS THE NEED?

Explain or attach why the current strategies are ineffective. Describe what more is needed.

RISKS & BENEFIT

Describe a risk and benefit analysis for the use of the restraint, isolation or protective equipment.

RESTRAINTS, ISOLATION OR PROTECTIVE EQUIPMENT

Identify proposed procedure or device and why these strategies are needed.

ATTACH RELAVANT PHOTOS, MANUFACTURER SPECIFICATIONS OR LITERATURE.

Procedure / Device	Purpose	Plan (Specify where procedure or device used, when, length of time, etc.)	Desired Outcome

PHYSICIAN ORDERS

Include written authorization by a physician, identifying the type of restraint ordered, the indication for its use, and the time period for its application.

INTERVENTION

Describe or attach the sequential process during which less restrictive measures will be used that precedes the use of restraints.

REDUCTION AND ELIMINATION PLAN FOR RESTRAINTS, ISOLATION OR PROTECTIVE EQUIPMENT

Describe or attach the plan for reducing and eventually eliminating the need for restraints.

TRAINING

Describe or attach the plan to provide initial and on-going training for staff. Identify who will conduct the training, his/her credentials, the duration of training, and how the training will be documented.

REVIEW

Describe or attach how the plan will be monitored, documented and reviewed.

INDIVIDUALS HAVING INPUT INTO THE SUPPORT PLAN

Name	Relationship to Consumer

PLAN REVIEW

Plan Reviewed By	Name	Signature	Date reviewed
Consumer, if not under guardianship *			
Guardian, if applicable *			
Placing Agency *			
Provider Agency *			
Behavior Consultant or Specialist			
Primary Physician			
Other:			
Other:			

* Required signatures